Main challenges in Denmark, Finland, Ireland and the Netherlands

The general problem is similar in all four countries under review: large-scale labour market exclusion of people with health problems or disability on the one hand and widespread dependence on health-related benefits putting pressure on the social protection system on the other. A closer look at country-specific outcomes, however, shows that the countries are facing different key challenges, as summarised in Tables 0.1 and 0.2.

Table 0.1. **Main challenges in Denmark, Finland, Ireland and the Netherlands**

Selected key policy issues[a]	Denmark	Finland	Ireland	Netherlands
Controlling incapacity-related public spending	+++	+++	+	++++
Raising employment rates for people with health problems	++	++	++++	+++
Tackling lower incomes of households with disabled people	++	+	++++	+
Reducing the inflow into sickness and disability benefits	+++	++++	+++	++
Addressing the increase in mental health conditions	+++	+++	++	+++
Raising the outflow from permanent disability benefits	+++	+++	++	++
Strengthening co-ordination between actors and systems	++	+++	+++	++

a) The scales should be interpreted as follows: "+" minor challenge; "++" moderate challenge; "+++" substantial challenge; and "++++" formidable challenge.

Source: Authors' assessment.

Table 0.2. **Selected key outcomes in Denmark, Finland, Ireland and the Netherlands**

Selected key outcomes[a]	Denmark	Finland	Ireland	Netherlands
Spending on sickness benefits (in % of GDP)	0.9 (↔)	1.1 (↔)	0.7 (↗)	2.3 (↔)
Spending on disability benefits (in % of GDP)	1.8 (↔)	1.9 (↔)	0.7 (↗)	2.4 (↔)
Employment rate of disabled people (%)	52 (↗)	54 (↔)	37 (↘)	45 (↘)
Unemployment rate of disabled people (%)	7.6 (↘)	14.2 (↘)	7.7 (↗)	8.0 (↗)
Disabled people with less than upper secondary education (%)	35 (↘)	29 (↘)	60 (↘)	44 (↘)
Disabled workers with less than upper secondary education (%)	25 (↔)	20 (↘)	43 (↘)	31 (↘)
Disabled people below 50% of the median income (%)	12 (↗)	8 (↗)	25 (↗)	6 (↘)
Income of disabled people relative to non-disabled peers (%)	86 (↔)	89 (↔)	68 (↘)	84 (↘)
Workers on sickness absence over all workers (%)	5.1 (↗)	3.3 (↗)	4.3 (↔)	4.0 (↘)
Disability benefit inflows in 1000 of the working-age population	4.1 (↔)	9.4 (↔)	8.9 (↔)	3.7 (↘)
Disability benefit inflows with mental health problem (%)	46 (↗)	33 (↔)	. .	43 (↗)
Disability benefit recipients over age 50 (%)	64 (↘)	75 (↔)	51 (↔)	61 (↗)
Disability benefit recipients in % of the working-age population	7.1 (↔)	8.4 (↔)	6.0 (↗)	8.5 (↘)
Annual outflow from disability benefits in % of current recipients	~ 0	1	. .	3.0 (↘)
Inclusion error: non-disabled people on disability benefit (%)	51	31	47	33
Exclusion error: disabled people without benefit or work (%)	2	1	4	8

. . Data not available.

a) Figures refer to 2007 or most recent year available. Information in parentheses refers to the trend in the past few years when it is available: falling (↘), constant (↔) or rising (↗). For an explanation for the relative income poverty figure for Denmark, see the corresponding section in Chapter 1.

Source: Details on the outcome indicators are available from the analytical chapters of this report.

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Chapter 3

Into and Off Benefit: The Role of the State

Early action is important to avoid that health conditions develop into more serious problems, eventually leading to a disability benefit claim. Denmark and the Netherlands have introduced guidelines for sickness absence monitoring of workers. Such monitoring is lacking in Finland and Ireland. In addition, countries need to do more to identify and assist people with health problems when they are not regularly employed, or unemployed. The Netherlands is the only country where specific guidelines have been set up recently to address health-related work barriers of this group.

At the same time, effective re-integration measures are needed as people with disabilities experience substantial difficulties to exit disability benefits and to find sustainable employment. Denmark has taken big steps in promoting employment in the regular labour market through the use of wage-subsidies, but more can be done to prevent misuse of these "flex-jobs". On the contrary, a large proportion of people with health problems in the Netherlands remain on sheltered employment. Ireland and Finland lack systematic referral to employment services which limits the chances of activation for people with disabilities.

This chapter addresses policies to curb the inflow into disability benefits and to encourage outflow from these benefits. High and sometimes increasing disability benefit recipiency rates need to be addressed, first, by limiting entry into and, then, by promoting exit from benefits. High inflows can be tackled by improving sickness management and rehabilitation and by ensuring stricter assessment criteria. Outflow from benefits is often low, partly because of the difficulty to recover from health limitations, and partly because of low efforts to promote vocational rehabilitation and employment among recipients.

The chapter's main focus is on the role of the state and on what public policies are doing in limiting inflow and increasing outflow, and what they could be doing. As such, it does not describe in detail the role of other actors which is addressed in subsequent chapters. In particular, the role and incentives of employers are discussed in Chapter 4, and those of working and non-working individuals in Chapter 5. Chapter 6 provides a more in-depth analysis of institutional structures and incentives.

The structure of the chapter is as follows. The first section gives an overview of the process from sickness to disability in the four countries from the point of view of the state. It discusses the most frequent pathways into disability benefits and policies designed to monitor absence of sick workers and those aimed at people with health problems who are not working. This is followed by a description of the ways in which disability is being assessed and how these access criteria influence inflows into disability benefits. The second section looks at the importance of rehabilitation and activation measures to end long-term benefit dependency. The last section summarises the policy challenges that the four countries are facing in this area.

3.1. Leaving the labour market onto benefits

This section describes the various ways in which countries are monitoring sickness absence and looks at what more could be done in this field, particularly for those who are unemployed when they fall ill. A description of the different assessment criteria illustrates the challenges in controlling access to disability benefits, particularly among those with mental health problems.

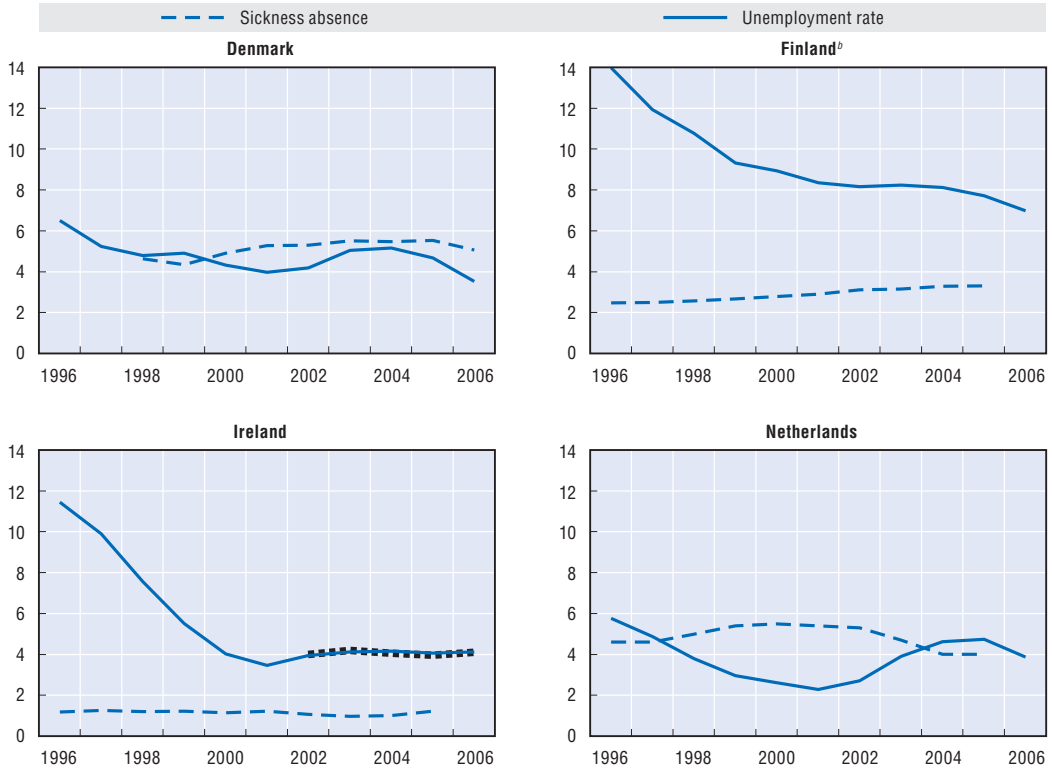
A. Health and absence monitoring of sick workers

Levels of sickness absence are around 4-5% of the workforce in all four countries when measured from the first day of absence (3.3% in Finland, as shown in the chart, when excluding absences with duration of less than nine days). Absence rates are highest and somewhat above the OECD average in Denmark and around 4% in the other three countries. The rates have been relatively stable over time in both Denmark and Ireland, while absence rates have been decreasing in the Netherlands. In Finland, on the contrary, sickness absence has increased by 20% in the past ten years, and by almost 50% for absences of long duration.

Sickness absence in Denmark, Finland and most significantly in the Netherlands evolves in a countercyclical manner: sickness absence increases during times of economic expansion and decreases when unemployment is high (Figure 3.1). In the Netherlands, a 1% increase in unemployment has been found to decrease sickness absence by 0.25%

Figure 3.1. **Sickness and unemployment are inversely related, especially in the Netherlands**

Share of workers absent from work and share of unemployed labour force (percentage), 1996-2006[a]



a) To derive the sickness absence rate, the total number of annual absence days is calculated by multiplying the number of spells by the average duration of each spell. This result is divided by the labour force resulting in the average number of days of sickness per person. These figures are further divided by the number of actual working days (statutory minimum annual leave and paid public holidays are removed) in each country. For Ireland, the long-term sickness absence series is an estimate from the EULFS giving the share of employees absent from work due to illness, injury or temporary disability *during the whole week* prior to the survey. The short-term series which is only available for 2002-2006 (black dotted line) is taken from administrative records and measures sickness absence from the *first day of absence*, as the data for the other three countries.

b) Waiting periods and employer-paid periods are included for all countries with the exception of Finland. Data for the other countries suggest that a comparable rate for Finland would be approximately 0.5 percentage points higher than the figures shown in the chart.

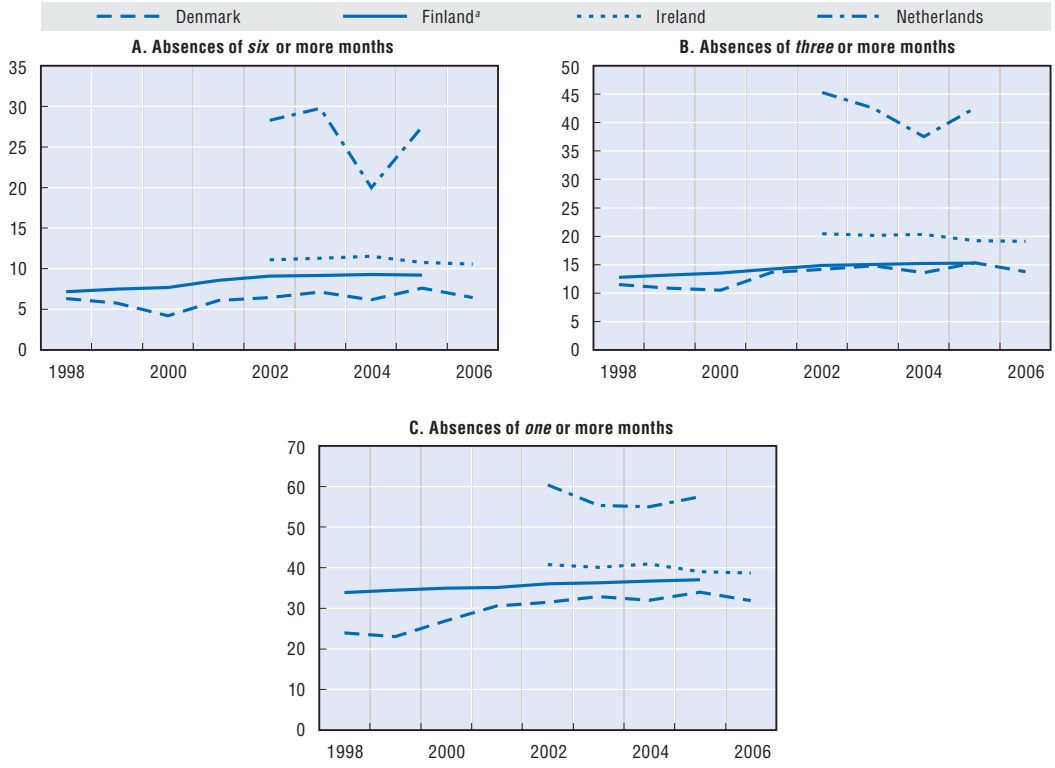
Source: For unemployment, *OECD database on Labour Force Statistics*; for sickness data, Denmark, Ministry of Employment (DREAM database); Finland, KELA; Ireland, EULFS (LFS series) and DSFA (administrative series) and the Netherlands, CBS.

(Jehoel-Gijsbers, 2007). Several economic theories provide an explanation for the relation between unemployment and sickness: firstly, during booms working conditions might get worse (because of more time pressure and on-the-job stress), leading to more accidents and deteriorating health; secondly, it is also possible that during booms marginal workers with worse health enter the labour force; finally, high unemployment may have a disciplining effect on workers by increasing the fear of being laid off.

The share of long-term absences is similar in Denmark, Finland and Ireland, irrespective of the definition of long-term (Figure 3.2). The Netherlands stand out as having much higher shares of long-term absence, presumably partly due to underreporting of shorter-term absences (given that there are no public absence statistics collected any longer) and partly to the longer duration of full-wage payments in the case of absences. In Denmark and especially Finland, the increase in overall absence levels is largely driven by a slow but steady increase in longer-term absences, especially those with durations between one and three months. This in turn is believed to be partially related to a composition

Figure 3.2. **Long-term absence is increasing in Denmark and Finland but is highest in the Netherlands**

Long-term sickness absence spells as a share of all absence spells, 1998-2006



a) For Finland, the period refers to 150 days or more.

Source: Danish Ministry of Employment (DREAM database); KELA (Finland); DSFA (Ireland) and CBS (the Netherlands).

effect stemming from the increase in employment of more vulnerable groups, particularly the chronically ill. Another factor identified for Denmark is the increase in jobs with a high level of absence such as childcare workers, social and healthcare personnel (Lund *et al.*, 2007). In Ireland, on the contrary, the share of longer-term absences is falling recently.

Governments should have a strong interest in monitoring medical conditions and the work capacity of people on sickness benefits to identify potential risk cases early and avoid the transfer to long-term benefits. Eligibility checks and stricter screening have been found to increase reintegration efforts and work resumption rates during sickness absence in the Netherlands (de Jong *et al.*, 2007). Similarly, in Sweden, postponing monitoring by delaying a doctor's certificate was found to increase the duration of sickness absence (Hesselius *et al.*, 2005). Timing and an effective control of the causes for sickness absence appear to be essential elements for governments in designing their sickness management process.

To curb their high absence rates, both Denmark and the Netherlands have put in place a process of earlier intervention and absence monitoring, although performed by different actors. In the Netherlands, employers or rather the company's contracted occupational health service providers are in charge of following up workers' illnesses. In Denmark, the primary responsibility rests with the municipalities, which have an incentive in limiting long-term sickness absence because the state will not reimburse these costs after 52 weeks; during the first year, the state and the municipality share the costs on a 50/50 basis.[1] In the Netherlands, there has been a switch towards an internalisation of sickness costs, as